



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Fort Duncan Medical Center

Respondent Name

Hartford Fire Insurance Co

MFDR Tracking Number

M4-15-3761-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable per ASC Rule 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: \$39.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found that reimbursement was made in accordance with Rule 134.403 and additional reimbursement would not be recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 30, 2014	73080, 99283	\$39.90	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 802 – Charge for this procedure exceeds the OPPS schedule allowance
 - P12 – Workers compensation jurisdictional fee schedule adjustment
 - W3 – Additional payment made on appeal/reconsideration
 - 193 – Original payment decision is being maintained

- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The services in dispute will be calculated as follows;

- Procedure code 73080 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.41. This amount multiplied by the annual wage index for this facility of 0.7926 yields an adjusted labor-related amount of \$27.27. The non-labor related portion is 40% of the APC rate or \$22.94. The sum of the labor and non-labor related amounts is \$50.21. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$50.21. This amount multiplied by 200% yields a MAR of \$100.42.
 - Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of \$166.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$99.87. This amount multiplied by the annual wage index for this facility of 0.7926 yields an adjusted labor-related amount of \$79.16. The non-labor related portion is 40% of the APC rate or \$66.58. The sum of the labor and non-labor related amounts is \$145.74. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$145.74. This amount multiplied by 200% yields a MAR of \$291.48.
2. The total allowable reimbursement for the services in dispute is \$391.90. This amount less the amount previously paid by the insurance carrier of \$392.58 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	August , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.